

Medicare Advantage Prior Authorization Genetic testing request form



Please complete this form in its entirety and fax to 866-287-5834.

Member information			
Member name		HealthSpring ID	
Member address	City	State	ZIP
Member date of birth / /	Phone		

Requesting provider's information			
Name		Phone	
Address	City	State	ZIP
Taxpayer identification number			
National Provider Identifier			
Office contact name			
Phone	Fax		
Date of service, if applicable			
Laboratory name (if doing institutional billing, include the name of the performing laboratory)			
Address	City	State	ZIP
TIN			
NPI			
Diagnosis description			
ICD-10 code(s)			
Is this a panel test? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Collection or completion date		Sample type	
Proprietary test names or gene names			
Procedure codes			